services are provided to school age individuals as defined in Section 33-201, Idaho Code. (12-31-91)

18. Eligibility Manuals. Idaho Department of Health and Welfare Rules, Title 03, Chapter 01, "Rules Governing Eligibility for Aid for Families with Dependent Children," and Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled." (11-10-81)

19. Emergency. Any situation arising in the medical condition of a patient, which, after applying the prevailing medical standards of judgement and practice within the community requires immediate medical intervention. All obstetrical deliveries are considered emergencies. (10-29-92)

20. Endangerment of Life. A condition where, in the opinion of two (2) licensed physicians, a pregnant woman may die or suffer severe and long lasting physical health damage if the fetus is carried to term. (1-16-80)

21. Health Authority. An authorized official of any of the seven (7) Idaho District Health Departments or their satellite centers. (1-16-80)

22. Home Health Services. Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in Idaho Department of Health and Welfare Rules, Title 03, Chapter 07, Subsection 002.11., "Rules for Proprietary Home Health Agencies." (12-31-91)

23. In-patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (11-10-81)

24. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (2-5-93)

25. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance recipients. Such a team is composed of: (7-1-94)

a. At least one (1) registered nurse; and (7-1-94)

b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (7-1-94)

i. A consultant physician; or (7-1-94)

ii. A consultant social worker; or (7-1-94)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (7-1-94)

26. Interested Physician. (11-10-81)

a. A physician who performs a Medicaid funded abortion for a fee; or (11-10-81)

b. A physician who is related by blood or marriage to another physician performing a Medicaid funded abortion. (11-10-81)

27. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatoria. (11-10-81)

28. Law Enforcement Authority. An agency recognized by the state of Idaho in enforcement of established state and federal statutes. (11-10-81)

29. Legend Drug. A drug that requires by federal or state regulation, the order of a licensed medical practitioner before dispensing or administration to the patient. (11-10-81)

30. Licensed Psychologist. An individual who is licensed to practice psychology under Chapter 23, Title 54, Idaho Code. (10-6-88)

31. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (11-10-81)

32. Lock-in Program. An administrative sanction, required of recipients found to have misused the services provided by the Medical Assistance Program, requiring the recipient to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (11-10-81)

33. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (11-10-81)

34. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (11-1-86)

35. Non-legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (11-10-81)

36. Nurse Midwife. A registered nurse (RN) who is currently licensed to practice in Idaho, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules, Regulations, and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one of the following provisions: (11-10-81)

a. Is currently certified as a Nurse Midwife by the American College of Nurse Midwives; or (11-10-81)

b. Has satisfactorily completed a formal educational program of at least one (1) academic year that: (11-10-81)

i. Prepares a RN to furnish gynecological and obstetrical care to women during pregnancy, delivery and postpartum, and care to normal newborns; (11-10-81)

ii. Upon completion, qualifies a RN to take the certification examination offered by the American College of Nurse Midwives; (11-10-81)

iii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iv. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

37. Nurse Practitioner. A registered nurse (RN) who is currently licensed to practice in this State, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules, Regulations, and Minimum Standards pro-

mulgated by the Idaho State Board of Nursing, and who meets one of the following provisions: (11-10-81)

a. Is currently certified as a Primary Care Nurse Practitioner by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates, or by the Nurses Association of the American College of Obstetricians and Gynecologists; or (11-10-81)

b. Has satisfactorily completed a formal one (1) year academic year educational program that: (11-10-81)

i. Prepares a RN to perform an expanded role in the delivery of primary care; (11-10-81)

ii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iii. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

38. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for residents. The residents must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision; which are made available to them only through institutional facilities, not primarily for care and treatment of mental diseases. The institution is licensed in the state of Idaho pursuant to Section 39-1301, Idaho Code and is certified as a nursing facility pursuant to 42 CFR 405.1120 through 405.1136. (7-1-94)

39. Orthotic. Pertaining to or promoting the straightening of a deformed or distorted part. (10-1-91)

40. Orthotic and Prosthetic Professional. An individual certified or registered by the American Board for Certification in Orthotics and/or Prosthetics. (10-1-91)

41. Otologist. A licensed physician who specializes in the diagnosis and treatment of hearing disorders and diseases of the ear. (11-10-81)

42. Out-patient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of hospital bed accommodation. (11-10-81)

43. Out-of-state Care. Medical service that is not provided in Idaho or bordering counties are considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (2-15-93)

44. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (11-1-86)

45. Patient. The person undergoing treatment or receiving services from a provider. (11-10-81)

46. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (10-1-91)

47. Physician's Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one of the following provisions: (11-10-81)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (11-10-81)

b. Has satisfactorily completed a program for preparing physician's assistants that: (11-10-81)

i. Was at least one (1) academic year in length; and (11-10-81)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (11-10-81)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (11-10-81)

48. Plan of Care. A written description of medical, remedial and/or rehabilitative services to be provided to a recipient, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (10-6-88)

49. Premium or Subscription Charge. The per capita amount paid by the Department for each eligible MA recipient enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a recipient receives care and services during the contract period. (11-10-81)

50. Property. The homestead and all personal and real property in which the recipient has a legal interest. (11-10-81)

51. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (10-1-91)

a. Artificially replace a missing portion of the body; or (10-1-91)

b. Prevent or correct physical deformities or malfunctions; or (10-1-91)

c. Support a weak or deformed portion of the body. (10-1-91)

52. Provider. Any individual, organization or business entity furnishing medical goods or services in compliance with chapter and who has applied for and received a provider number, pursuant to Section 020., and who has entered into a written provider agreement, pursuant to Section 040. (12-31-91)

53. Provider Agreement. An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)

54. Provider Reimbursement Manual. Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Provider Reimbursement in Idaho." (11-10-81)

55. Psychology Assistant. An individual who practices psychology under the supervision of a licensed psychologist when required under Chapter 23, Title 54, Idaho Code, and Section H of the "Rules of the Idaho State Board of Psychologist Examiners." (10-6-88)

56. Recipient. An individual who is receiving Medical Assistance. (11-10-81)

57. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for special olympics, and special day parties (birthday, Christmas, etc.). (10-6-88)

58. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX long term care for the Department. (7-1-94)

59. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (11-10-81)

60. Specialized Family Home. Living situation where a maximum of two (2) waiver recipients who do not require a skilled nursing service live with a provider family of residential habilitation services. (1-1-95)T

61. Subluxation. A partial or incomplete dislocation of the spine. (11-10-81)

62. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (6-21-90)

63. Title XVIII. That program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled. The term is interchangeable with "Medicare." (11-10-81)

64. Title XIX. That program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as "Medicaid," which is jointly financed by the federal and state governments and administered by the states. The term is interchangeable with "Medicaid." (11-10-81)

65. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a recipient of medical assistance. (11-10-81)

66. Transportation. The physical movement of a recipient to and from a medical appointment or service by the recipient, another person, taxi or common carrier. (10-6-88)

67. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants/recipients to Title XIX benefits in a NF. (7-1-94)

68. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the NFs approved by the Department as providers of care for eligible medical assistance recipients. (7-1-94)

69. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the recipient would be able to participate in a sheltered workshop or in the general work force within one (1) year. (10-6-88)

70. Waiver Facility. A licensed ICF/MR facility of eight (8) beds or less that has converted to a group home to provide residential habilitation services to developmentally disabled waiver recipients. Room and board is not included in the reimbursement rate. (1-1-95)T

004. ABBREVIATIONS. For these rules, the following abbreviations will be as defined: (7-1-93)

01. AABD. Aid to the Aged, Blind, and Disabled. (11-10-81)

02. AAP. American Academy of Pediatrics. (8-1-92)

03. APA. The Administrative Procedures Act, Title 67, Chapter 52, Idaho Code. (11-10-81)

04. A/R. Applicant/Recipient. (11-10-81)

05. ASC. Ambulatory Surgical Center. (9-30-84)

06. ASHA. American Speech and Hearing Association. (11-10-81)

07. B.I.A. Bureau of Indian Affairs. (11-10-81)

08. CFR. Code of Federal Regulations. (11-10-81)

09. CRVS. California Relative Value Studies. (11-10-81)

10. DME. Durable Medical Equipment. (11-1-86)

11. D.O. Doctor of Osteopathy. (11-10-81)

12. DVR. Department of Vocational Rehabilitation. (11-10-81)

13. EAC. Estimated Acquisition Cost. (11-10-81)

14. EOMB. Explanation of Medical Benefits. (11-10-81)

15. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (11-10-81)

16. ICF/MD. Intermediate Care Facility/Medical Disease. (11-10-81)

17. ICF/MR. Intermediate Care Facility/Mentally Retarded. (11-10-81)

18. IOC. Inspection of Care. (1-1-83)

19. IOCT. Inspection of Care Team. (1-1-83)

20. IRS. Internal Revenue Service. (11-10-81)

21. MA. Medical Assistance. (11-10-81)

22. MAC. Maximum Allowable Cost. (11-10-81)

23. M.D. Medical Doctor (11-10-81)

24. MMIS. Medicaid Management Information System. (11-10-81)

25. NF. Licensed Nursing Facility. (8-1-92)

26. PASARR. Preadmission Screening and Annual Resident Review. (7-1-94)

27. PSRO. Professional Services Review Organization. (11-10-81)

28. QMHP. Qualified Mental Health Professional. (7-1-94)

29. QMRP. Qualified Mental Retardation Professional. (4-30-92)

30. REOMB. Recipient's Explanation of Medicaid Benefits. (11-10-81)

31. R.N. Registered Nurse. (4-30-92)

32. RSDI. Retirement, Survivors, and Disability Insurance. (11-10-81)

33. SMA. State Maximum Allowance. (11-10-81)

34. SSA. Social Security Administration. (11-10-81)

35. SSI. Supplemental Security Income. (11-10-81)

36. S/UR. Surveillance and Utilization Review. (11-10-81)

37. TPL. Third Party Liability. (11-10-81)

38. UC. Utilization Control (7-1-94)

39. UCT. Utilization Control Team. (7-1-94)

40. UR. Utilization Review. (11-10-81)

005. SINGLE STATE AGENCY AND STATEWIDE OPERATION. The Idaho Department of Health and Welfare has the authority to administer the Title XIX Medical Assistance Program on a statewide basis in accordance with standards mandatory throughout the State and set forth herein. (11-10-81)

006. -- 009. (RESERVED).

010. PUBLIC ACCESS TO PROGRAM INFORMATION (7-1-93)

01. Location of Rules Governing Medical Assistance. A current copy of the rules governing medical assistance, as well as other MA program information affecting the public, is to be maintained by the Department in the Central Office and in each field office. (11-10-81)

02. Availability of Materials. Copies of the rules governing medical assistance or other MA program information affecting the public will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules and Regulations, Title 5, Chapter 1, "Rules Governing the Protection and Disclosure of Department Records (Confidentiality)": (11-10-81)

a. Formally requests specific information; or (11-10-81)

b. Formally requests to be placed on a mailing list to receive amendments to MA program policy from the Department's Administrative Procedure Section. (11-10-81)

03. Cost of Materials. A fee, to cover actual reproduction costs, will be assessed for all requests for copies of information. (11-10-81)

011. -- 013. (RESERVED).

014. COORDINATED CARE. (6-1-94)

01. Establishment. The Department may, in its discretion, and in consultation with local communities, organize and develop area specific plans as part of a coordinated care program. (6-1-94)

a. Flexibility. Since community needs and resources differ from area to area, the Department will maintain the flexibility to design plans which are consistent with local needs and resources. (6-1-94)

b. Waiver Programs. Plans may be either voluntary, or mandatory pursuant to waiver(s) granted by the Health Care Financing Administration. Some plans may start as voluntary and subsequently become mandatory. (6-1-94)

c. Models. It is anticipated that coordinated care will be accomplished principally through primary care case management. However, capitated plans may also be utilized. (6-1-94)

d. Purpose. The purposes of coordinated care are to: (6-1-94)

i. Ensure needed access to health care; (6-1-94)

ii. Provide health education; (6-1-94)

iii. Promote continuity of care; (6-1-94)

iv. Strengthen the patient/physician relationship; and, (6-1-94)

v. Achieve cost efficiencies. (6-1-94)

02. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (6-1-94)

a. "Clinic" means two or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs) and Certified Rural Health Clinics. (6-1-94)

b. "Coordinated care" is the provision of health care services through a single point of entry for the purposes of managing patient care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as "managed care." (6-1-94)

c. "Covered services" means those medical services and supplies for which reimbursement is available under the state plan. (6-1-94)

d. "Emergency care" means the immediate services required for the treatment of a condition for which a delay in treatment could result in death or permanent impairment of health. (6-1-94)

e. "Grievance" means the formal process by which problems and complaints related to coordinated care are addressed and resolved. Grievance decisions may be appealed as provided herein. (6-1-94)

f. "Non-exempt services" means those covered services which require a referral from the primary care provider. It includes all services except those that are specifically exempted. (6-1-94)

g. "Outside services" means non-exempt covered services provided by other than the primary care provider. (6-1-94)

h. "Patient/recipient" means any patient who is eligible for medical assistance and for which a provider seeks reimbursement from the Department. (6-1-94)

i. "Plan" means the area specific provisions, requirements and procedures related to the coordinated care program. (6-1-94)

j. "Primary care case management" means the process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient. (6-1-94)

k. "Qualified medical professional" means a duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (6-1-94)

l. "Referral" means the process by which patient/recipients gain access to non-exempt covered services not provided by the primary care provider. It is the authorization for non-exempt outside services. (6-1-94)

m. "Waiver" means the authorization obtained from the Health Care Financing Administration to impose various mandatory requirements related to coordinated care as provided in sections 1915(b) and 1115 of the Social Security Act. (6-1-94)

03. Primary Care Case Management. Under this model of coordinated care, each patient/recipient obtains medical services through a single primary care provider. This provider either provides the needed service, or arranges for non-exempt services by referral. This management function neither reduces nor expands the scope of covered services. (6-1-94)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the patient/recipient's care, providing primary care services, and making referrals for outside services when medically necessary. All outside services not specifically exempted require a referral. Outside services provided without a referral will not be paid. All referrals shall be documented in recipient's patient record. (6-1-94)

b. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: family planning services, emergency care, dental care, Podiatry, Audiology, Optical/Ophthalmology/Optometrist services, chiropractic, pharmacy, nursing home, ICF/MR services, and immunizations. (6-1-94)

04. Participation. (6-1-94)

a. Provider Participation. (6-1-94)

i. Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (6-1-94)

ii. Conditions and Restrictions. (6-1-94)

(1) Quality of Services. Provider shall maintain and provide services in accordance with community standards of care. Provider shall exercise his/her best efforts to effectively control utilization of services. Providers must provide 24 hour coverage by telephone to assure patient/recipient access to services. (6-1-94)

(2) Provider Agreements. Providers participating in primary care case management must sign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals. (6-1-94)

(3) Patient Limits. Providers may limit the number of patient/recipients they wish to manage. Subject to this limit, the provider must accept all patient/recipients who either elect or are assigned to provider, unless disenrolled in accordance with the next paragraph. Providers may change their limit effective the first day of any month by written request thirty (30) days prior to the effective date of change. (6-1-94)

(4) Disenrollment. Instances may arise where the provider/patient relationship breaks down due to failure of the patient to follow the plan of care or for other reasons. Accordingly, a provider may choose to withdraw as patient/recipient's primary care provider effective the first day of any month by written notice to the patient/recipient and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (6-1-94)

(5) Record Retention. Providers must retain patient and financial records and provide the Department or its agent access to those records for a minimum of five (5) years from the date of service. Upon the reassignment of a patient/recipient to another provider, the provider must transfer (if a request is made) a copy of the patient's medical record to the new provider. Provider must also disclose information required by section 040.01 of this chapter, when applicable. (6-1-94)

(6) Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in section 040.03 of this chapter. An agreement may be amended for the same reasons. (6-1-94)

iii. Payment. Providers will be paid a case management fee for primary care case management services in an amount determined by the Department. The fee will be based on the number of patient/recipients enrolled under the provider on the first day of each month. For providers reimbursed based on costs, such as Federally Qualified Health Centers and Rural Health Clinics, the case management fee is considered one hundred percent (100%) of the reasonable costs of an ambulatory service. (6-1-94)

b. Recipient Participation. (6-1-94)

i. Enrollment. (6-1-94)

(1) Voluntary Programs. In voluntary plans, the patient/recipient will be given an opportunity to choose a primary care provider. If the patient/recipient is unable to choose a provider but wishes to participate in the plan, a provider will be assigned by the Department. If a voluntary plan subsequently becomes mandatory, provider selection/assignment will remain unchanged where possible. (6-1-94)

(2) Mandatory Programs. In mandatory plans, a provider will be assigned if the patient/recipient fails to choose a participating provider after given the opportunity to do so. Members of the same family do not have to choose the same provider. All patient/recipients in the plan area are required to participate in the plan unless individually granted an exception. Exceptions from participation in mandatory plans are available for patient/recipients who: (6-1-94)

(A) Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary care services; (6-1-94)

(B) Have an eligibility period that is less than 3 months; (6-1-94)

(C) Live in an area excluded from the waiver; (6-1-94)

(D) Have an eligibility period that is only retroactive; or (6-1-94)